

JOINT LEGISLATIVE COMMITTEE ON AGING

2005 PUBLIC HEARING

Tuesday, May 24, 2005

Columbia, South Carolina

MEMBERS

Representative Denny W. Neilson, Chair

Representative Walton J. McLeod

Representative Thomas N. Rhoad

Senator Ronnie W. Cromer

Senator J. Yancey McGill

Senator Glenn G. Reese

Ms. Linda Johnson

Mr. Ollie Johnson

Mr. Bill Riser

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Executive Summary

Oral and written testimony was received from fifteen speakers. Presenters in order of appearance and a brief synopsis of information presented below.

Cornelia D. Gibbons, Director, Lt. Governor's Office on Aging

Presented accomplishments since July 1, 2004 when Office on Aging was transferred from DHHS to Lt. Governor (see handout). Priorities for 2005-06 include addressing sustainable funding for services to seniors; the loop hole in Bingo tax legislation; coordination of accessible transportation; expand SC ACCESS and the ADIC "one stop shop" model.

Seniors' Impact on SC: Today and Tomorrow:

- Maximize opportunities that in-migration of affluent mature adults presents for economic growth and improving tax base
- Encourage private sector to create services that our aging population clearly is willing to purchase
- Plan to meet aging population's health needs and support a sustainable quality of life
- Manage workforce issues presented by caregivers who are torn between careers and family responsibilities
- Encourage personal responsibility so that certain inevitable services like long term care are purchased by individuals rather than funded as entitlements

Tom Lloyd, Speaker, Silver Haired Legislature

2005 Resolutions for South Carolina General Assembly

- Increase number of ombudsmen
- Criminal background checks for in-home and adult daycare providers
- Transportation for an affordable fee
- Increase in funding for abused seniors
- In-Home and Community Based Services
- Tax credits for payment of long term care insurance premiums
- Funding for the SC Silver Haired Legislature
- Access to Long Term Care Information

Lynnda C. Bassham, Director Human Services, Lower Savannah Council of Governments

- Support continuation and expansion of Aging and Disability Information Center
- Support for continued home and community-based service options
- Support for philosophy of consumer direction

Libby Conkrite, Private Citizen, Aiken County

- Continued support for Aging and Disability Information Center

Teresa Arnold, Legislative Director, AARP of South Carolina

- Funding for community based services to allow persons to remain in their homes and to promote consumer independence, dignity, autonomy and privacy

Hannah Timmons, SC Education Association, Retired

- Increase retirement benefits and annual COLA guaranteed
- Improve health, dental and pharmaceutical drug insurance
- Fund public schools and the EFA adequately
- Oppose funding of private schools with public money
- Revise the current SC tax structure

Vickie Williams, President, SC Association of Area Agencies on Aging

- Advocate for raises in the authorized Older Americans Act funding levels
- Inclusion of an education and training certification program for AAA Directors
- Educational training in gerontology and geriatrics in the health and social service professions targeted to ensure that an adequate force of skilled service providers are available to provide aging network services

Maria Patton, Alzheimer's Resource Coordination Center

- Caregiver support in the form of emotional support, family support, and support groups
- Information and resources on Alzheimer's disease
- Respite services for caregivers of patients with Alzheimer's disease
- Funding for the above continuum of services needed by families of patients with Alzheimer's disease

Mary E. Peters, President, CARE for LIFE

Managing the care of aging parents is rapidly becoming the forefront of family issues today. Two-thirds of working caregivers report conflict between work and family. Sixty-four percent of caregivers of the elderly are employed and caregiver stress accounts for a twenty-seven percent increase in use of company health insurance benefits. The Baby Boom Generation will spend up to eighteen years caring for an elderly parent. There is a great need to provide a broad range of eldercare services to working family caregivers. Coordinating health care and community resources to reduce work and family conflict should be a main priority for state planning.

Susan Carlton, Executive Director, South Carolina Respite Coalition

Respite is needed for anyone who is caring for someone 24 hours a day. It is the top need identified by family caregivers of children and adults alike. Respite is regular, intermittent breaks from round the clock care giving.

- The first need is for respite to be easily found. A central point of contact is needed so that families have to make only one or two phone calls for sitters, referrals and financial help
- Families want respite to be offered in group settings and in the home
- Crisis respite should be available
- Families should be able to select their respite care providers
- Policy considerations must also include those caring for someone with mental health issues

Erika T. Walker, Director, The SAGE (Supporting the Advancement of Geriatric Excellence) Institute

Three (3) top service weakness areas: transportation, mental health, middle economic level services. Develop a Senior Service Committee to present to the Legislature important issues from across service sectors. The Committee would better be able to focus on seniors as customers crossing all economic levels and all care needs. Focus on replicating senior service best practices not dependent on government funding.

Lynn Stockman, Executive Director, Newberry County Council on Aging

- Councils on Aging receive funding to maintain programs for our older generation through which they can remain independent and retain their dignity

Sue Scally, Ph.D., Private Citizen

- Expand concept of consumer choice to all public funding for long term care services
- Recognize that informal care is the backbone of the long term care system and must be supported by public policy
- Support federal legislation that will permit SC and other states to implement a program that improves access to affordable private long term care insurance

Tom Sweeney, Coalition for Successful Aging

- He is with MassMutual Financial Group and also serves on the Coalition for Successful Aging. Is ready to help with any issues related to education of long term care insurance

Helen Dills Pittman, Private Citizen

- House the Area Agencies on Aging at the Clemson Extension Services in each county.

Joint Legislative Committee on Aging
2005 Public Hearing
Tuesday, May 24, 2005
Room 101, Blatt Building,
Columbia, South Carolina

Welcome and Opening Remarks

Representative Denny W. Neilson

Rep. Denny Neilson welcomed everyone to the public hearing and thanked them for taking time from their busy schedules to attend the hearing. She stated that the Joint Legislative Committee on Aging needs to hear from folks so that the Committee can provide the legislation that is needed to help provide services for the seniors of South Carolina.

Representative Neilson introduced the Committee members present:

Representative Walton J. McLeod, Representative Thomas N. Rhoad, Senator J. Yancey McGill, Senator Glenn G. Reese, Ms. Linda Johnson, Mr. Ollie Johnson and Mr. Bill Riser.

She stated that Senator Ronnie Cromer was not able to attend.

Election of Officers: Representative Neilson was nominated and unanimously elected Chair of the Joint Legislative Committee on Aging.

Representative Neilson thanked her legislative aid, Betsy Marchant for her assistance with coordinating the public hearing and Judi Davis from the Lt. Governor's Office on Aging for recording the hearing.

Representative Neilson said that each presenter would be allotted 5 minutes to speak and that each speaker should be prepared to give a copy of their written remarks to the committee.

Cornelia D. Gibbons

Thank you for giving me the opportunity to speak to you today. I have given you a detailed handout and I will just summarize with you the high points in the remarks. It has been an exciting year and a lot has happened since we were here last year and since aging was moved under Lt. Governor André Bauer. He has provided us excellent leadership and a wonderful opportunity for us to reach out to our senior community and start some very exciting and innovative things.

Selected Accomplishments since July 1, 2004

Cost Efficiencies

1. Reduced rent approximately \$40,000 per year in lease for new office. The office moved January 3, 2004 to 1301 Gervais St, Ste 200, 29201.
2. Reduced staff from 46 to 34. (46 included 6 TGE slated to terminate 9/30 1 to transfer to DHHS.) Net adjusted reduction of 7 staff.
3. Assumed full responsibility for all operations. Association with DHHS ended on January 3, 2005.

Direct Services to Seniors

4. 31,657 persons were served with Older Americans Act and related funds during State FY 2003-2004.
5. The number of nursing home and residential care facility complaints reported to the Long Term Care Ombudsman Program increased from 4,911 complaints in 2003 to 5,251 complaints in 2004.
6. During FY 2003-2004 the state's aging network provided information, referral and assistance services to 55,976 persons.
7. During FY 2003-2004 13,359 persons were provided insurance counseling through the State Health Insurance Information Program through individual contacts or outreach events. An additional 58,573 persons were reached through media events.
8. During FY 2003-2004 12,507 persons were served through the Senior Medicare Patrol Program through individual contacts, suspected fraud complaints or outreach events. An additional 67,820 persons were reached through media events.
9. During FY 2004-2005 the ten Area Agencies on Aging were awarded a total of \$20,015,896 in federal, state and local funds to provide for the local service delivery to approximately 35,000 older adults in South Carolina.
10. \$500,000 currently has been awarded during FY 2004-2005 through the Permanent Improvement Project grant program. \$1,300,000 is currently in the RFP process to be awarded in September, 2005.
11. \$150,000 has been awarded for FY 2004-2005 to grantees for the Alzheimer's Resource Coordination Center program (ARCC) for projects to assist persons or caregivers of persons with Alzheimer's disease or related dementias.
12. \$33,268 was collected through the Elder Care Trust Fund for Calendar Year 2004. Five projects are currently funded to assist seniors in South Carolina: two for medication

awareness, two for senior home repairs, and one for operating an Alzheimer's disease social day care program.

13. Competitively procured the Title V Senior Employment contract for the first time.
14. 2005-2008 State Plan on Aging has been approved by the Administration on Aging.
15. Received a \$15,000 grant from the Administration on Aging in September, 2004 for the Advanced Performance Outcomes Measurement Project.
16. The Catawba AAA Board has been reconstituted to comply with federal & state funding requirement.

New Initiatives

17. Created the Lieutenant Governor's Office on Aging electronic newsletter – September, 2004.
18. Developed a legislative agenda for 2005 with support from AARP, Silver-Haired Legislature, and long term care industry.
19. Formed the LGOA's Commission on Aging for Review and Evaluation. The CARE is working in conjunction with the Coalition on Successful Aging to assist with the development of aging issues that need to be addressed by the State of South Carolina.
20. Opened South Carolina's first Aging and Disability Resource Center (ADIC) in Aiken and Barnwell December 1, 2004.
21. RFPs to competitively procure all Older Americans Act services were issued Jan. 2005. Contracts to be implemented by the state's ten Area Agencies on Aging on July 1, 2005. Won't save money but expect to purchase more services with the same dollars.
22. Legislation was introduced to create a Geriatric Loan Forgiveness Program to assist physicians in repaying their loans as an inducement to practice geriatric medicine in South Carolina. Key sponsors: Nathan Ballentine and Ray Cleary.
23. Created SC Access (a web-based directory designed to help older South Carolinians and others who need long-term care supports locate the services available in their local community). The LGOA is currently updating and enhancing the system for public roll-out during the summer of 2005.
24. Negotiated agreement with residential care industry, AARP and Silver-Haired Legislature to start a Volunteer Ombudsman program during 2005. Plans to implement the program are under way, and a training manual has been developed.
25. Realigned our budget to transfer approximately \$320,000 from COLA to fund 5 Ombudsmen for local programs. An additional \$52,000 will be transferred to fund a Volunteer Ombudsman position provided for the FY 2005-2006 State Appropriation's Act.
26. In the process of developing a Senior's Rent Assistance Program in conjunction with the State Housing Authority for the next two years. The program will initially be funded with \$1,000,000.
27. Working with USC School of Public Health, Office of the Study on Aging, on a joint grant from the National Institute on Aging to develop and test the feasibility, validity, and reliability of methodologies for measuring the prevalence and incidence of elder mistreatment.

28. Working with USC School of Public Health, medical school and MUSC on a joint grant from Duke Endowment to develop data necessary to plan for and evaluate impact on SC of in-migration and to provide policy research to help the state address the needs of seniors in a cost effective manner.
29. The SC White House Conference was held on April 25-27, 2005 at Springmaid Beach, Myrtle Beach for providing recommendations to the WHC in DC in October 23-26, 2005. 399 persons attended, and over \$63,000 were raised privately through sponsorships and registration fees. Historically has been funded by state. The South Carolina White House Conference on Aging was the largest state event in the nation.

Seniors' Impact on SC: Today and Tomorrow

Our Seniors *State of the State*

Tremendous demographic changes are occurring in South Carolina. The state's 60 plus population is expected to double to 1.3 million by 2025. South Carolina's growth rate of older adults over the past decade ranked ninth in the nation.

Maturing baby boomers comprise a senior community growing from two directions: the in-migration of retirees moving to our state and our indigenous aging population. These demographic changes will result in two senior communities with different expectations and needs for public services.

Our more affluent in-migrants will fuel the economy while expecting scenic beauty, recreational and cultural opportunities and modest taxes while our less fortunate seniors will depend on state services including Medicaid, housing, transportation, and other social services. The synergy between the two senior communities can benefit our state economically if we plan well for our future.

The growth of the senior population in SC presents both business opportunities and challenges that must be addressed in a partnership between the corporate community and public sector if we are to assure a sustainable quality of life.

Five Critical Issues have been identified that will significantly impact the future quality of life for all South Carolinians. While time only permits me to list these five issues, I have attached an addendum with detailed supportive data and information.

Critical Issues

- I. Maximize the opportunities that the in-migration of affluent mature adults presents for economic growth to improve our tax base.
- II. Encourage the private sector to create the services our aging population is willing to purchase.
- III. Plan to meet our aging population's health needs and support a sustainable quality of life.
- IV. Manage the workforce issues presented by caregivers who are torn between careers and family responsibilities.
- V. Encourage personal responsibility so that certain inevitable services like long-term care are purchased by individuals rather than funded as entitlements.

2005 South Carolina White House Conference on Aging

The five critical issues just discussed were key discussion areas at the South Carolina White House Conference. The 399 participants provided excellent ideas and policy direction both for the nation and our state. The delegates voted to establish their priorities for the SC platform that goes to the National White House Conference in October. The summary results follow:

Issue	# of Delegate Votes	Percentage
Health Care	91	33%
Senior. Friendly Communities	58	21%
LTC	30	11%
Caregiving	26	9%
Planning for the Future	23	8%
Housing	19	7%
Alzheimer's	13	5%
Research	8	3%
Workforce	6	2%
In-Migration	2	1%
Total Votes	276	

Priorities for FY2005-06

The LGOA will work with our partners under the leadership of Lieutenant Governor André Bauer and his CARE Commission to establish our 2006 legislative and programmatic agenda. Our goal will continue to be to use solid data and sound research to advise you on critical policy issues that need to be addressed to assure that our growing senior population does in fact have the opportunity to enjoy a sustainable quality of life. We also must address sustainable funding for services to our seniors. The loop hole in the Bingo tax legislation must be addressed as well as the need for additional resources to serve the 3,670 seniors on waiting lists in our local communities. Coordination of accessible transportation is an essential. And, we must expand SCAccess and the ADIC “one stop shop” model so that our seniors and their families can easily find and access the services they need. André and his CARE Commission will help guide us through the next year to make wise and thoughtful decisions that maximize services in the most cost effective manner.

In closing, let me first thank Lieutenant Governor André Bauer for his exemplary leadership and support. He has truly opened the door to allow us to address the needs of our senior population. My thanks also go to our aging network – the 10 Area Agencies on Aging and the Councils on Aging and other local service providers. And, a special thank you to our partners in advocacy: The Silver Haired Legislature and AARP.

For additional information, please contact:

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Seniors' Impact on SC: Today and Tomorrow

Discussion of Five Critical Issues

- I. Maximize the opportunities that the in-migration of affluent mature adults presents for economic growth and improving our tax base.
 - a) SC is currently ranked No. 5 in the nation for net in-migrants. These newcomers have average annual incomes of \$110,000 and net worths of \$1 million; 80% have college degrees; and a significant number have entrepreneurial plans.
 - b) Their top 5 ranked demands for products and services in decreasing order: banking services, furniture, automobile, residential realtor, home mortgage.
 - c) In-migrants will create \$2.2 billion in annual living expenditures, purchase 13,000 homes for \$7.4 billion, and pay annually \$3,350 on average in state and local taxes.
 - d) It takes 3.7 new manufacturing jobs to equal the impact of one affluent retire household due to leakage and lifestyle issues.
- II. Encourage the private sector to create the services our aging population clearly is willing to purchase.
 - a) These affluent seniors, both those in-migrating and indigenous, share a common predicament. At some point in their lives they can foresee the need for assistance such as transportation, personal care, and nutrition. Currently they are concerned because few businesses are offering the services they will require.
 - b) Throughout the statewide hearings on the aging plan, seniors said that they were seeking a system that allows people with discretionary income to purchase these services.
- III. Plan to meet our aging population's health needs and support a sustainable quality of life.
 - a) Neither poor health nor disabilities is an inevitable consequence of aging, especially if we prepare for our mature years by promoting good health, preparing financially to meet our health needs, preventing chronic disease and postponing disability and institutionalization for older adults.
 - b) Senior health issues have less to do with funding since 97% are covered by health insurance, and more to do with lack of access to preventative services and failure to coach good lifestyle decisions.
 - c) Children born in 1900 could expect to live to 47, while newborns in 2000 could expect 77 years. These extra 30 years are largely due to a major shift in the leading causes of death. Last century it was infectious diseases and acute illness. In our time it is chronic diseases and degenerative illnesses. The key to a longer life in this 21st century involves individual decisions to adopt regular physical activity, a healthy diet and a smoke-free lifestyle. And, importantly, it involves individuals having access to a physician so they can get regular health screenings.
 - d) Although covered by Medicare, only one third of older Americans are receiving the benefits of immunizations and cancer screening, medicine's most effective tools for preventing some

of the leading causes of death. Meanwhile, lifestyle decisions to smoke, to eat poorly, and to be physically inactive were responsible for one out of every three deaths in 2000.

e) One in seven seniors in South Carolina lives below the poverty level, and should be dually qualified for both Medicaid and Medicare health coverage. Another group of seniors, with incomes less than 200% of poverty, potentially qualifies for Medicaid sponsorship of their long-term care needs. Almost one in four women 60 years or older lives at or below the poverty level.

f) The Centers for Medicare and Medicaid predicts dramatic increases in spending for nursing home costs (\$178.8 billion by 2012) and home health care spending (\$68.9 billion by 2012). Historically, in South Carolina, home health/community-based care has increased from \$500,000 in 1981 to \$93.6 million in 2002 while long term nursing care services have increased from \$78 million in 1981 to \$318.7 million in 2002.

IV. Manage the workforce issues presented by caregivers who are torn between careers and family responsibilities.

- a) Throughout our country a new sandwich generation is emerging, so named because they are sandwiched between raising their children and caring for their elderly relatives. About 44 million full-time workers are also caring for family members because they cannot afford a professional caregiver.
- b) About 15% of the workforce leaves annually to be full-time caregivers. The indirect cost to American business of workers informally providing long term care is \$29 billion in terms of retraining, absenteeism, productivity loss, and other related costs.
- c) There are 364,800 family caregivers in South Carolina. They provide 339.6 million hours of care per year at an estimated value of over \$2.7 billion.
- d) 83% of persons (primarily friends and family members) who provide informal care for seniors are age 51 or older themselves. The majority of caregivers provide unpaid assistance for one to four years; 20% provide care for five years or longer.
- e) When 1,500 caregivers stop working, \$22 million in purchasing power is lost to the SC economy.
- f) Without caregivers, 50% of the recipients being cared for would go to a Medicaid nursing home and cost the state \$7.4 million in state funds to provide Medicaid nursing home care for one year.
- g) 43,020 persons in South Carolina 65 and older have Alzheimer's disease. By 2025, 125,190 South Carolinians will have Alzheimer's disease. The average lifetime cost of an Alzheimer's patient is \$174,000 and the estimated cost of the disease in the U.S. each year is \$100 billion dollars. Assuming a 5% cost of inflation, the cost of Medicaid nursing home care for persons in South Carolina with Alzheimer's disease and dementia will be \$2.6 billion by 2025.

V. Encourage personal responsibility so that certain inevitable services like long-term care are purchased by individuals rather than funded as entitlements.

- a) Less than 10% of Americans have purchased long term care insurance. Most long-term care expenses are not paid directly by consumers, but by government programs, primarily Medicaid.

- b) Social Security, with pensions, provides the bulk of retiree income. Over one-fourth of South Carolinians 50 and over depends solely on Social Security for income. In 2000, there were 411,216 retired workers in South Carolina receiving Social Security benefits with an average monthly benefit of \$812. Total benefits equal \$4 billion annually.
- c) Seniors are the fastest-growing group of debtors in the U.S. In 1992, only 35 percent of seniors carried debt, but this figure increased to 59 percent by 2000. Nearly 23 percent of seniors 75 and over had debt in excess of 40 percent of their income in 1998. The frequency of bankruptcy among seniors has also jumped 244 percent from 1991-2002. There are a variety of reasons for this increasing debt, such as insufficient funds for retirement, low interest rates and a sluggish stock market, climbing medical bills, major home repairs, and loans to family members. Seniors who find themselves in financial crisis may seek debt counseling, and should take advantage of programs available to seniors such as homestead tax exemption, reverse mortgages, and prescription drug and energy assistance.

South Carolina White House Conference on Aging Recommendations in Priority Order

Priority Issue #1: Health Care

Seniors, as well as other age groups, have been poorly educated on the importance of nutrition, immunizations, physical fitness, the dangers of tobacco use and chronic disease management. In addition few are actively participating in preventive strategies for better health. Lack of availability of chronic disease management and health prevention/wellness services result in increased senior health problems, healthcare costs and greater incidence of chronic illness.

Barriers:

Funding, transportation, legislative process and agency bureaucracies, lack of knowledge of healthy lifestyles, apathy, disparity in services for minority populations, lack of knowledge of cultural diversity, ageism, access and affordability, lack of trained professionals, complicated and unclear language, language and cultural barriers (i.e. Hispanic), personal attitudes, lack of empathy from medical community

Proposed Solution(s):

1. Raise the federal tax on tobacco products to fund the prevention and treatment of chronic disease.
2. Develop a federal Health Care Task Force of health care professionals and lay people to oversee the Medicare program and ensure scientifically based, cost effective, quality preventive care and treatment of acute and chronic disease.
3. Redirect existing funds and stimulate public and corporate cooperation with tax incentives, national tobacco tax, recycle health related equipment, financial incentives for adapting healthy life styles and ensuring affordable and quality health prevention and treatment programs for seniors.

Priority Issue #2: Need to Develop Senior Friendly Communities

Seniors need and have the right to affordable, reliable, accessible transportation. Urban and rural senior friendly transportation is needed to promote independence and access to services.

Barriers:

Money/funding, background checks, fragmented funding, liability, rising cost of fuel, lack of training, lack of coordination of services, lack of communication about services, automated telephone systems, availability of volunteers, single rides, lack of knowledge of replicable projects, variety of services as required by location – urban/rural.

Proposed Solution(s):

1. Legislation that protects providers/entities from liability.
2. Remove restrictions on FTA funds to allow availability at a lower rate match to agencies that provide transportation to seniors, to allow expansion of transportation to access seniors to communities and services.
3. Develop and implement senior friendly, affordable, ADA compliant transportation for rural and urban communities which would allow seniors to remain independent.

Priority Issue #3: Long Term Care and Continuum of Care

Restructure Medicaid/Medicare and develop private and personal funding incentives for financing and providing additional flexible options for LTC continuum.

Barriers:

Lack of available funds, political turf wars, increased population, how care is financed, passing-the-buck attitude, lack of interest, federal regulations, lack of coordination between federal and state programs, lack

of training in Geriatrics, entitlement mentality, lack of state and federal representatives demonstrating interest, inappropriate Medicaid asset transfers, institutional bias, lack of education about programs available, language and cultural differences, lack of education for politicians on the needs of seniors, wartime economy

Proposed Solution(s):

1. To educate the public and policymakers regarding the needs of the population for LTC services, current resources, description of services and the need for increased flexibility and reimbursement to reflect the true cost of quality care.
2. To establish a coalition to educate policymakers and elected officials, at the national, state and local levels, about restructuring Medicare/Medicaid to deal with current and projected issues.
3. To establish a program of equitable co-pay, based on income and assets for any person in the US or its territories who accesses the continuum of care.

Priority Issue #4: Caregiving

The National Family Caregiver Support Program does not adequately address the needs of the two target populations: the caregivers taking care of seniors 60 and older, and seniors 60 and older caring for dependent children age 18 and younger.

Barriers:

Government/politics, lack of awareness of caregiving epidemic, funding issues, business and industry cooperation, adequate support services often not available, inadequate family/caregiver financial resources, unfair distinction in the system between rural and urban areas, lack of awareness of what it is to be a caregiver, lack of uniform national services, lack of coordination and collaboration, caregiver denial/embarrassment/isolation/confidentiality leads to reluctance to ask for help, age eligibility requirements

Proposed Solution(s):

1. Increasing the Title III-E funding to meet the growing needs of caregivers;
2. Add additional staff for advocacy (elected officials and public), training and support; and
3. Empowering the caregiver through maintained flexibility and consumer direction.

Priority Issue #5: Planning for the Future

There is a need for a quality comprehensive, coordinated information system that links agencies, organizations, and individuals to resources to support seniors and a plan to communicate those services to improve seniors' quality of life.

Barriers:

Inadequate funding, ineffective communication, political ignorance, standards of quality, lack of coordination between existing programs, redundancy, weak organizations

Proposed Solution(s):

1. Create a national task force to educate the politicians on the need for adequate funding for a comprehensive high quality information system.
2. The Department of Health and Human Services should develop a partnership among federal agencies and the private sector to fund and implement a national information system network.
3. Implement a sustained multimedia educational initiative informing the public and the appropriate agencies about available services and resources and services for older adults.

Priority Issue #6: Housing

There is a lack of proper and sufficient funding for adequate, affordable and accessible housing and supportive services for all seniors.

Barriers:

Red tape, lack of knowledge (government, seniors, family, and community) about housing needs/choices and the supportive services needed to age in place, annual budget cuts for new housing and subsidized housing programs, funding for senior housing is not a legislative priority, lack of economic resources, partisan politics and “pork barreling”, insensitivity to senior issues, international issues versus local issues, apathetic public and government officials’ attitudes towards public policy, resistance to change

Proposed Solution(s):

1. Take care of home first by reallocating some funds presently allocated to international issues to accessible housing and supportive services for all seniors.
2. Provide federal financial incentives to the states to encourage partnerships and collaborative efforts to educate legislators, community leaders, seniors, and families on the need for and availability of various housing options.
3. Modify the Older Americans Act to change the WHCoA to being held every 5 years in order to more frequently evaluate and modify national policy related to senior issues including, but not limited to, senior housing needs.

Priority Issue #7: Impact of Alzheimer’s Disease

The impact of Alzheimer’s disease and related dementias in the United States is costing families, businesses and government billions of dollars. The number of people who will be affected by these diseases will reach epidemic proportions within the next decade.

Barriers:

Ignorance, competition for funds, tendency to address crises rather than fund prevention activities, persons with dementia cannot advocate for themselves; caregivers are often burned out, stigma related to Alzheimer’s disease and related dementias, cost of war is impacting funding for other priorities, lack of collaboration with research on other prevention initiatives, competition between agencies, unwillingness to take personal responsibility for healthier lifestyles, cultural barriers, nobody wants to increase taxes

Proposed Solution(s):

1. Urge Congress to recognize and acknowledge the impending epidemic of Alzheimer’s disease and related dementias and its impact on families, businesses and government.
2. Recommend that Congress enact legislation to support prevention, education and research on Alzheimer’s disease and related dementias in order to delay onset of dementia and curb associated financial burdens.
3. Funding to support this legislation should be a minimum of one billion dollars yearly for the next five years.

Priority Issue #8: Research

Establish a patient centered model of collaboration among health care/and human service providers, researchers, insurance companies and drug companies to promote lifestyle changes and preventive care.

Barriers:

Lack of collaboration among government agencies for research funding, lack of self accountability (quick fix mentality), focus on treatment rather than prevention, strong lobby by drug industries for treatment versus prevention, lack of public awareness of research findings, health insurance does not provide coverage for preventive services, patient/provider trust issues, lack of communication between providers and patients, geriatrics is a low prestige research specialty, inadequate reimbursement for Medicare, lack of funding in the aging field, lack of interest among funding resources in prevention, aging research lacks urgency in our society

Proposed Solution(s):

1. Increase funding for wellness and preventative research.
2. Include evidence based outcomes in research.
3. Inform and educate all stakeholders about wellness and preventive care research.

Priority Issue #9: Workforce Issues

We are not adequately preparing for an aging workforce or providing options to enhance & encourage continued employment.

Barriers:

Age discrimination and unsubstantiated myths of older workers, work place disincentives to remaining employed in the concept of retirement as a required rite of passage, challenges of low skilled, low income older workers with multiple barriers to employment who must work to maintain the basic essentials of life including food, shelter, clothing and medical care, unavailability of meaningful training/retraining, reluctance of employers to explore work options

Proposed Solution(s):

1. Educate the business community and market the value of older workers and their ability to learn and adapt.
2. Encourage public and private research that identifies employer and employee needs and interests of an aging workforce.
3. Offer adequate training and funding in traditional or non-traditional settings that targets seniors.

Priority Issue #10: In-Migration

Federal allocations of resources to address the Medicaid eligible population and other services for the older population need to more aggressively take into account the rapid in-migration of the retiring population among the states, rather than basing allocations only on census data.

Barriers:

Categorical allocations for services from federal level limit the ability of the states to address locally documented needs, precedents, or “that is the ways things have always been done,” hinder progress, dependence on outdated census data prevents equitable resource distribution in the “between Census” years, especially in fast growing states, opening the discussion of resource allocation usually sets in motion opposition from the various special interest groups, the resistance of Congress to work on a bipartisan basis prevents the achievement of positive change, the complexity of issues requires significant expenditure of time to achieve satisfactory solutions

Proposed Solution(s):

1. The federal government shall allow states greater flexibility to address state and local level needs with budget appropriations.
2. For a more favorable allocation of federal resources, the method to determine each state's allocation of federal funds shall be updated on a mid-decade basis.
3. Encourage more active participation of the private sector as arbiters and consensus builders in the political process of finding solutions to aging issues.

2005 Legislative Priorities of the



Bringing together the wisdom and experience of older South Carolinians



The sixth session of the SCSHL was held in the Chambers of the South Carolina House of Representatives on September 14-16, 2004.

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South Carolina Silver Haired Legislature

Thomas Wm. Lloyd
Speaker 2003-2005

The South Carolina Silver Haired Legislature, created in 1999 by statute, is one of 31 state groups in the United States including the District of Columbia, Puerto Rico, and the Virgin Islands. Seniors in the state of Missouri formed the first Silver Haired Legislature in 1973.

The South Carolina Silver Haired Legislature, a unicameral body with the potential of having 80 representatives and 80 alternates from the counties of the state, was created by the General Assembly initiating in the House of Representatives and signed by Governor James H. Hodges. (Act 84, 6 /11/99) Focus groups involved in the forming of the South Carolina Silver Haired Legislature were the SC Area Agencies on Aging Association, SC Council on Aging Directors Association, SC Federation for Older Americans and the SC Department of Health and Human Services Office of Senior and Long Term Care.

The South Carolina Silver Haired Legislature was created:

- To identify issues, concerns and possible solutions for problems facing the aging population in South Carolina;
- To make recommendations to the Governor, General Assembly and various Departments and agencies on aging;
- To arrange and participate in educational forums to explore issues related to older South Carolinians;
- To promote good government for all South Carolinians;
- To carry out its purposes and activities on a nonpartisan basis; and
- To conduct its general assembly sessions annually in the State Capital.

The South Carolina Silver Haired Legislature held its first organizational and orientation meeting for its members on July 14, 1999 at the Capital Senior Center in Columbia, SC. All legislative sessions have been held at the State Capitol in the chambers of the SC House of Representatives. Regional member caucuses meet throughout the year. During this time the members prepare resolutions (similar to bills) to be presented to the Speaker, who then, based on the topics, dispenses them to six named committees in which all members can participate. The legislative committees then debate their resolutions and present three to the Speaker. These resolutions are presented to the membership for discussion, voting, and listing in priority order for presentation to the SC General Assembly, the Governor, and others in South Carolina.

Regional area caucuses work with the Area Agencies on Aging, which play an important role in the ongoing local activities. Each AAA assists the regional caucus of representatives and alternates with issues affecting SC seniors and in the coordination of interests through development of resolutions to be presented in Columbia for discussion and confirmation.

History and Text of Bill Creating South Carolina Silver Haired Legislature

General Bill #3477 introduced in the House of Representatives 1999-02-04

Primary Sponsor: Neilson

Other Sponsors: Seithel, Sharpe, J. Brown, J. Smith, R. Smith, Rhoad, Lucas, Davenport, Lee, Mason, Altman, Keegan, Harrison, McCraw, Clyburn, J. Hines, Bales, Lourie, Lanford, Bauer and Tripp

Ratification #153 - passed both bodies: 1999-06-03

Act #84 - signed by Governor: 1999-06-11

AN ACT TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 43-21-190 SO AS TO CREATE A NONPARTISAN MODEL LEGISLATURE ON AGING ISSUES TO BE ADMINISTERED BY THE SOUTH CAROLINA SILVER HAIRED LEGISLATURE, INC.; TO PROVIDE FOR THE PURPOSES OF THE LEGISLATURE; AND TO PROVIDE THAT PARTICIPANTS MUST BE SELECTED PURSUANT TO PROCEDURES ADOPTED BY THE SOUTH CAROLINA SILVER HAIRED LEGISLATURE IN COORDINATION WITH THE STATE'S NETWORK OF AGING PROGRAMS.

Be it enacted by the General Assembly of the State of South Carolina:

Silver Haired Legislature established

SECTION 1. The 1976 Code is amended by adding: "Section 43-21-190. There is created a model legislature on aging issues to be administered by the South Carolina Silver Haired Legislature, Inc. This model legislature shall: (1) identify issues, concerns, and possible solutions for problems facing the aging population in South Carolina; (2) make recommendations to the Governor and members of the General Assembly and to the Joint Legislative Committee on Aging; (3) arrange educational forums to explore issues related to older South Carolinians; (4) promote good government for all South Carolinians. The participants must be sixty years of age or older and must be selected pursuant to procedures adopted by the South Carolina Silver Haired Legislature, Inc., in coordination with the state's network of aging programs. The nonpartisan model legislature shall conduct its general assembly annually."

Time effective

SECTION 2. This act takes effect upon approval by the Governor.

Ratified the 9th day of June, 1999

Approved the 11th day of June, 1999

In Memory of...

James J. Califf, Horry County

Frank A. Cartee, Pickens County

Dorothy H. Dukes, Dorchester County

Cyril (Cy) J. Kaemmerlen, Cherokee County

Charles A. McCown, Florence County

Elizabeth Scruggs, Williamsburg County

Judson M. Terrell, Greenville County

Claude Vernon, Cherokee County

B. A. "Gus" Wentz, Anderson County

South Carolina Silver Haired Legislature

2004-2005 Board of Directors

Speaker – Tom Lloyd – Lexington

Speaker Pro Tem – Chester Tomson – Orangeburg

Secretary – Arliss Hinson – Anderson

Records Clerk – Hannah Timmons – Richland

Treasurer – Betty Morris – Lexington

Immediate Past Speaker – Roy Mathis – Charleston

AREA CAUCUS	CAUCUS CHAIR	MEMBER
#1 - <i>Appalachia</i>	Eugene Bondurant – Greenville	Charles Latimer – Greenville
#2 - <i>Upper Savannah</i>	Molly Harts – Greenwood	Mary Elizabeth Ouzts – Edgefield
#3 - <i>Catawba</i>	Henrietta Massey – York	Loyce Sutton – York
#4 - <i>Central Midlands</i>	Charles McNeill – Lexington	Charles Blakely – Richland
#5 - <i>Lower Savannah</i>	Guy Suter – Barnwell	Barbara Lewis – Allendale
#6 - <i>Santee-Lynches</i>	Jesse Coleman – Sumter	Millie Stradford – Kershaw
#7 - <i>Pee Dee</i>	Hazel Hatchell – Marion	Barbara Leonard – Florence
#8 - <i>Waccamaw</i>	Mary Ann Baucom – Horry	Jo Small – Horry
#9 - <i>Trident</i>	David Unwin – Charleston	Viola Wright – Charleston
#10 - <i>Low Country</i>	Ruth Reeves – Colleton	Gladys Jones – Jasper

Committees of the Board of Directors

Advocacy	Elections	Finance	Judiciary
Ruth Reeves, Chair	Viola Wright, Chair	Eugene Bondurant, Chair	Hazel Hatchell, Chair
Jessie Coleman	Arlis Hinson	Mary Ann Baucom	Charles Blakely
Molly Harts	Jo Small	Gladys Jones	Charles Latimer
Barbara Lewis	Mary Elizabeth Ouzts	Betty Morris	Barbara Leonard
Charles McNeill	Millie Stradford	Loyce Sutton	Henrietta Massey
Chester Tomson	David Unwin	Guy Suter	Hannah Timmons

South Carolina Silver Haired Legislature

2005 Resolutions

to be presented to the First Session of the 116th General Assembly of South Carolina

1st Priority ~ INCREASE IN NUMBER OF OMBUDSMEN

WHEREAS, there are more than 40,000 residents in South Carolina who receive nursing home care and many more in residential care facilities statewide;

WHEREAS, there are only 15 paid staff ombudsmen statewide to monitor conditions and investigate complaints in these nursing homes and residential care facilities;

WHEREAS, almost 5,000 abuse complaints were received by the Long Term Care Ombudsmen Program in 2003 from these facilities, and many more went unreported because of fear of reprisals and abuse;

NOW, THEREFORE BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to increase the number of ombudsmen to a level needed to ensure that the laws and regulations governing the care and quality of life of patients in South Carolina nursing homes and residential care facilities are monitored and enforced and that all patient and family complaints are heard and resolved as quickly as possible.

2nd Priority ~ CRIMINAL BACKGROUND CHECKS FOR IN-HOME AND ADULT DAYCARE PROVIDERS

WHEREAS, many South Carolinians choose to remain in their homes as they age;

WHEREAS, most of these Seniors at sometime in their lives require some in-home and/or adult daycare;

WHEREAS, there are many cases of abuse and criminal behavior perpetrated by some in-home and/or adult daycare service providers;

NOW, THEREFORE BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to require criminal background checks for all paid professional in-home and adult daycare service providers.

3rd Priority ~ TRANSPORTATION FOR AN AFFORDABLE FEE

WHEREAS, the South Carolina Senior adult population is increasing rapidly;

WHEREAS, many Seniors, who are not eligible for Medicaid transportation, live in communities with no access to public transportation for appointments, shopping, or social activities;

WHEREAS, having access to transportation prolongs independent living;

NOW THEREFORE, BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to fund a transportation program for an affordable fee to the elderly of South Carolina, regardless of financial status.

4th Priority ~ INCREASE IN FUNDING FOR ABUSED SENIORS

WHEREAS, adult protective service departments across the state of South Carolina have had problems providing safe emergency shelter for the numerous elderly who are victims of abuse, neglect, and exploitation;

WHEREAS, volunteers and adult protective services across the state are attempting to provide around the clock care for those who are vulnerable because of frailty and dependence;

WHEREAS, present funding is inadequate to provide for the medications, food, shelter, rent, supplies, and services needed to care for abuse victims who must be removed from their homes;

NOW, THEREFORE BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to provide increased funding for medications, food, shelter, rent, supplies and services for adult abuse victims who have been removed from their homes.

5th Priority ~ IN-HOME AND COMMUNITY-BASED SERVICES

WHEREAS, the South Carolina older citizen population is growing rapidly;

WHEREAS, most older adults prefer to age in place;

WHEREAS, in-home and community-based services, which are less costly than out-of-home care, greatly reduce costs to older adults, their families, and/or taxpayers;

NOW, THEREFORE, BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to increase state funding for all in-home and community-based services for older citizens.

Additional 2005 Resolutions

approved but not voted as priorities for the 2005 session of the General Assembly

TAX CREDITS FOR PAYMENT OF LONG TERM CARE INSURANCE PREMIUMS

Whereas, long term care causes significant financial burdens to individuals and families;
Whereas, the number of South Carolinians who need long term care is increasing;
Whereas, privately purchased long term care insurance can prevent reliance on Medicaid, thus greatly reducing costs to taxpayers;

NOW, THEREFORE, BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:
That the South Carolina General Assembly enact and the Governor sign legislation to provide a state income tax credit to any person who pays a premium for long term care.

FUNDING FOR THE SOUTH CAROLINA SILVER HAIRED LEGISLATURE

WHEREAS, the nonpartisan South Carolina Silver Haired Legislature was established by the General Assembly in 1999 under Act 84, with no funding to support its advocacy mission on behalf of the more than 650,000 Senior Citizens 60 years of age and older;
WHEREAS, attempts at SCSHL fund-raising have proved to be ineffective and have distracted from the established mission to recommend, advise, and promote issues to benefit state Seniors;
WHEREAS, a monetary need exists for the SCSHL to function as an organization;

NOW, THEREFORE, BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:
That the South Carolina General Assembly enact and the Governor sign legislation to allow state taxpayers to contribute from their state tax refund to support the South Carolina Silver Haired Legislature, using a check-off box on their South Carolina income tax forms.

ACCESS TO LONG TERM CARE INFORMATION

WHEREAS, with the rapid increase in South Carolina's Senior population, more older citizens and their families are seeking long term care information;
WHEREAS, information is essential not only to provide for the best quality of long term care but also to assure safe and secure care;
WHEREAS, numerous statewide forums have identified the difficulties older citizens and their families are experiencing trying to access long term care information and aid with the application for services process;

NOW, THEREFORE, BE IT RESOLVED BY THE SC SILVER HAIRED LEGISLATURE:
That the South Carolina General Assembly enact and the Governor sign legislation to facilitate funding for and establishment of a readily available single point of long term care services information.

DEBT FORGIVENESS FOR DOCTORS WHO SPECIALIZE IN GERIATRIC MEDICINE

Whereas, many South Carolina doctors will not accept new patients on Medicare or Medicaid;
Whereas, those who will accept Medicare or Medicaid patients have increasingly long waiting lists;
Whereas, the situation has become critical for Medicare or Medicaid patients who move or whose doctors retire or die;

NOW, THEREFORE, BE IT RESOLVED BY THE SC SILVER HAired LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to provide debt forgiveness of \$25,000 per year, up to a maximum of four years, to graduates of South Carolina medical schools who practice geriatric medicine and accept Medicare or Medicaid patients and payments in South Carolina.

ELIMINATION OF SALES TAX ON FOOD STAMP ELIGIBLE PRODUCTS

Whereas, the sales tax on food places an undue hardship on many South Carolina residents, especially older residents, many of whom live on a limited income;
Whereas, the food tax impacts a basic quality of life;
Whereas, the sales tax is the most regressive of all taxes;

NOW, THEREFORE BE IT RESOLVED BY THE SC SILVER HAired LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to reduce the sales tax on all food stamp eligible products one per cent (1%) per year until the state sales tax is eliminated.

QUARTERLY PAYMENT OF REAL ESTATE TAXES

Whereas, the number of older citizens residing in South Carolina is growing rapidly;
Whereas, paying county real property taxes all in one lump sum provides many older citizens with undue financial hardship;

NOW, THEREFORE BE IT RESOLVED BY THE SC SILVER HAired LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to allow South Carolina citizens the option of paying their county *ad valorem* taxes on real property in scheduled quarterly installments similar to the federal income tax payment schedule.

IMPROVED BILLING PRACTICES FOR MEDICAL SERVICES

Whereas, more and more South Carolina Senior Citizens are being hospitalized with various illnesses;

Whereas, many of these individuals have great difficulty understanding the billing process of these various institutions which provide medical services;

NOW, THEREFORE, BE IT RESOLVED BY THE SC SILVER HAired LEGISLATURE:

That the South Carolina General Assembly enact and the Governor sign legislation to require such institutions to present their bills in a more understandable and informative way to Senior patients.

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Lt. Governor André Bauer

Madam Chairwoman and members of the Committee,

I would appreciate just a moment. I know Nela Gibbons from my office has already spoken and I don't know what she covered because I just came in; but I would just like to say that tomorrow in the full Medical Affairs Committee, the Geriatric Bill will be taken up. Rep. Nathan Ballentine pushed this piece of legislation through the House. The House overwhelmingly passed it and it came to the Senate. It has passed the subcommittee and is now before the full Committee tomorrow. I invite any of the committee members or others present here today to stop by and let me know that they would like to see this piece of legislation passed. I think it's one of the most important things affecting our seniors to get more geriatric physicians that specialize in looking after our seniors. We currently have less than 1 per county which is not a very good ratio with our state's population continuing to age. This is a big piece of legislation that we would like to see passed this year and start to encourage young people in medical school to practice geriatrics. That's my big push today.

I thank you for what you are doing for our seniors. South Carolina is a leading state when you talk about seniors. It's the 5th largest in the country for influx of in-migration into South Carolina. So, a lot of people are watching what we're doing in South Carolina. We're excited about what we're doing and we thank you for what you're doing.

Rep. Neilson: Thank you for being here.

Senator McGill: Not so much a question but we appreciate your deep commitment to the seniors of this state. A lot of light has been spread across the state for our seniors since you have taken over. You and Ms. Gibbons have done a marvelous job along with staff members. We want to just say to you, Lt. Governor, keep up the good work for our seniors in SC.

**JOINT LEGISLATIVE COMMITTEE ON AGING
ANNUAL PUBLIC HEARING**

May 24, 2005

Lynnda C. Bassham, Director Human Services
Lower Savannah Council of Governments

Good afternoon. I am Lynnda Bassham, Director of Human Services for Lower Savannah Council of Governments. It is an honor to be able to speak with you today about a special pilot project on which we have been partnering with the Lt. Governor's Office on Aging.

In 2003 South Carolina was one of 12 states selected by the federal Administration on Aging and the Centers for Medicare and Medicaid Services to pilot a new approach to how older consumers, persons with disabilities and their families and caregivers access long term supports in the community.

The federal vision for this program is the creation of a network of aging and disability resource centers that serve as visible and trustworthy sources of information to help people understand their long term care options and help them to access services in a simplified, coordinated manner. The State Office on Aging invited the Lower Savannah Region to serve as the pilot area for South Carolina's Aging and Disability Information Center.

In our region we call our aging and disability resource center an *information center* because that is a term consumers better understand. The purposes of our Aging and Disability Information Center are:

- To make it easier for older individuals and adults with physical disabilities to access an array of health and social supports
- To help persons stay healthy and active in their communities
- To support families in their efforts to care for their loved ones at home and in the community
- To minimize confusion, promote individual choice and support informed decision-making by creating a single, coordinated system of information and access
- To streamline access to services and benefits for seniors and adults with physical disabilities by
 - Simplifying intake, eligibility screening and determination processes
 - Integrating and coordinating the process between programs and agencies

The Lower Savannah Council of Governments is the sponsor for the Aging and Disability Information Center. The pilot area includes Aiken and Barnwell Counties; however, the Council of Governments serves a 6-county area: Aiken, Allendale, Bamberg, Barnwell, Calhoun, and Orangeburg. The Center will expand to cover all counties once the pilot has been completed.

- The Information Center represents a partnership of many agencies and organizations that serve older adults and adults with physical disabilities.
- The Information Center is physically located in Aiken and is available through a toll free telephone number: 1-866-845-1550.
- The Information Center is staffed by specialists in several areas: Information and Referral, Family Caregiver Support, Aging and Disability Benefits, Insurance Counseling, and Long Term Care Ombudsman Services.

Development of the Aging and Disability Information Center responds to a **high priority issue** for older adults and their caregivers. Surveys and forums have consistently revealed that the difficulty in getting service information is one of the most frustrating experiences elders and their caregivers encounter. Confusion about where to go for information, what services are available to help them and how to apply for services is a common experience. Consumers repeatedly ask for a more streamlined and coordinated system. We believe that our Information Center responds to this frustration and consumer satisfaction surveys being conducted by the University of South Carolina reflect people's gratitude in having somewhere to turn for help in navigating the system.

We are fortunate to have SC Access, the new web-based resource directory available through the Lt. Governor's Office on Aging, as a tool to assist us as we help consumers identify and connect with the services they need.

Despite the fact that the official kick-off was not until December 1, 2004, over 1600 contacts have been made with the Information Center in the six months from October through March 2005. The number of calls has been doubling almost monthly, indicating that the word is spreading about the Information Center and the work we're doing.

As a major enhancement of our Aging and Disability Information Center, we have added programs to link consumers to prescription drug benefits. We answer numerous questions about the new Medicare Part D benefit, help people to enroll, if needed, and provide training for front line staff of other agencies on programs that offer assistance with the cost of medications.

We are operating a pilot medication assistance program in which a Catholic sister, "loaned" to us by the Daughters of Charity, coordinates the work of 23 volunteers to complete the time-consuming paperwork, to be signed by their physicians, enabling medically indigent consumers to receive free prescription medications from drug companies. Since October, we have helped 307 people obtain over \$105,000 worth of free life-sustaining prescriptions. Our volunteers have given over 800 hours of service to this end during

these seven months and the program continues to grow as word spreads.

I also want to take this opportunity to commend the SC Department of Health and Human Services and the Lt. Governor's Office on Aging for their efforts to expand opportunities for consumer direction, allowing consumers to make more decisions about the services they receive: when, where, how and from whom they receive them. We have heard loud and clear from consumers that they want to receive services in their homes and they want to have control over who provides their care and how it is provided. I urge our state policy makers to support this priority, by finding ways to expand support for home and community-based service options and by supporting the philosophy of consumer direction. I also urge you to support the continuation and expansion of our information center and others like it to cover our state.

Taken together, improved access and consumer directed services will do much to move South Carolina's service delivery system into the 21st century and to ready us for the wave of babyboomers on our doorstep.

Following me is Libby Conkrite. I have told you about the concept and activity of our Aging and Disability Information Center; Libby will tell you what it has meant to her. Thank you.

LIBBY CONKRITE

Good afternoon.

Thank you for this privilege. I'm just going to briefly tell you a little bit about me. I'm 48 years old, I worked full time, I raised two (2) children, I'm divorced and on May 3, 2004, my life crumbled before me. I had a stroke and on June 12, 2004 I had another stroke. I spent 5 ½ weeks in the hospital. I lost my job, had no income, they are foreclosing on my home. Life can't get any worse unless I put a canopy over that nice ramp that I found through the Lower Savannah Council of Governments to help me have some quality of living.

I have what they call hemiplegic migraine headaches. I have no warning. I lose complete control of my right side and I just black out and fall down – the headache is excruciating. I take \$3,600 worth of medicine a month for me to be able to function. Today, I am here on my own; tomorrow I may be on my walker. I may have home health care in two weeks to help me bathe because I won't be able to use my right side. When all this happened to me, I didn't know what to do. I couldn't get any help; I didn't have any money; didn't have insurance; didn't have food; couldn't get to the doctor because I couldn't drive; didn't have family members that live close enough to help me. So, I was directed through "Acts of Caring" which is area churches working together, to the Lower Savannah Council of Governments who put me in touch with this medication assistance program and trust me, ladies and gentlemen, it works. I would not have medication today had I not been able to go to the Lower Savannah Council of Governments. Lynnda Basham, Cathy Lindler and Peggy Ellers, these folks in Aiken work real hard for folks like me. I have lost memory and if it wasn't for folks like them, I wouldn't be here. I get lost going to the grocery store. But if you looked at me today – I look healthy as a horse. But I'm not. I have applied for disability and was denied. They say there's something out there I can do – I guess you could work on your back if you had to. It's a process. But these folks do a terrific job. You go to the Lower Savannah Council of Governments and they help you with your medications, tell you that there is an attorney here who will work with you pro bono, there are doctors who will accept you at their clinic with no insurance, this agency here will ensure that your lights are not turned off. I'm 48 years old and know how devastated I was when all this happened to me. I can image being a senior and this happening.

I just appreciate everything that they have done for me.

AARP – SC Statement to the Joint Legislative Committee on Aging
May 24, 2005
Teresa Arnold – Legislative Director

Long-term services and supports should promote consumer independence, dignity, autonomy and privacy. To the extent they are capable, consumers should make their own decisions about and direct the long-term services and supports they receive. The federal government and the states should recognize and support consumer choices to the maximum extent possible.

Nationally, expenditures for long-term home and community based services have been growing more rapidly under Medicaid than have expenditures for institutional care, primarily because states are trying to serve more people in less costly HCBS settings, which is where most consumers want to be served. Despite the cost increases HCBS accounted for just 33 percent of total Medicaid LTSS spending in 2003; institutional care—including nursing homes and intermediate care facilities for people with mental retardation—accounted for 67 percent.

In South Carolina, \$421 million was expended on nursing home care for 16,626 people at \$25,000 per person. Nursing home expenditures grew 22% over a two year period. Community Long Term Care expenditures for services that allow people to remain in their homes totaled \$76 million in 2003 and had a growth rate of -7.0%. CLTC served 11,000 people at a cost of \$4,700 per person. CLTC only accounts for 15% of South Carolina Medicaid expenditures for long term care services, versus 85% for nursing home care. We spend half what the national average is on percentage of funding for services that help people remain home. The last time CLTC got an increase in funds was 1999. We need to develop policies that encourage home and community based care and gives people more options for their long term care. The bonus is that people are happier at home and it costs the state far less.

We have a waiting list for CLTC of 3400 individuals. Home-delivered meals and other community based services has a waiting list of 3,970 seniors. These are critical needs but funding them isn't just the right thing to do, it's the smart thing to do as it allows persons to remain in their homes at far less cost to society.

The South Carolina Education Association–Retired LEGISLATIVE PROGRAM – 2005

First Session of the 116th General Assembly of South Carolina

Retirement Benefits

Increase retirement benefits and an annual COLA guaranteed
Improve the health, dental, and pharmaceutical drug insurance

Education Finance

Fund public schools and the EFA adequately
Oppose funding of private schools with public money
Revise the current South Carolina tax structure

THE SOUTH CAROLINA EDUCATION ASSOCIATION–RETIRED
421 Zimalcrest Drive, Columbia, SC 29210
803-551-4150 — 803-551-4158 — 1-800-422-7232 (extensions 4150 & 4158)
Kermit McCarter, President — Hannah Timmons, Legislative Committee Chair

S. C. Association of Area Agencies on Aging



REPORT TO THE JOINT COMMISSION ON AGING HEARING

Tuesday, May 24, 2005

Madame Chairman and Commission members,

My name is Vickie Williams and I am here today as President of the South Carolina Association of Area Agencies on Aging to offer some comments from Association members.

Aging service delivery in South Carolina has recently undergone a transition to the formal procurement for Aging services. This was a two-year initiative that involved the Administration on Aging, the Lt. Governor's Office on Aging, Area Agencies on Aging, and local service providers. The transition process was difficult, but necessary as South Carolina positions itself to address the challenges of the next 20 years and the population shifts that will take place. 2005 and beyond will be critical years for Aging Policy with regard to several key programs including:

- Medicaid budget cuts / Medicaid reform;
- Medicare Modernization Act;
- Social Security and its solvency;
- Older Americans Act, FY 2006 appropriations; and most importantly
- The Older Americans Act Reauthorization.

The Older Americans Act was one of the foundational pieces for evolving public policy on Aging and the development of a nationwide Aging infrastructure. In 1965, when the Act was passed, its underwriters considered it a starting point for the provision of tangible and intangible help to innumerable older persons to stay in their homes and communities with maximum dignity and independence. Since that time there have been numerous changes in each reauthorization and, until recent years, steady increases in the amount of funding allocated to the States.

The South Carolina Aging Network: Partners Serving All Older South Carolinians
Catawba AAA – Central Midlands AAA – Elderlink, Inc. AAA – Lowcountry AAA – Lower Savannah AAA –
Santee-Lynches AAA – S.C. Appalachian AAA – Upper Savannah AAA – Vantage Point AAA – Waccamaw AAA

Since 1980, however, there has been a substantial loss in the Older Americans Act program's capacity at the State and community levels to provide services to older Americans. Shifts in population trends of those 60+ and those 18 and under, State budget cuts and variances in different revenue programs dedicated to Aging services, and shortfalls in local governmental revenues, require that communities, policy makers, and the Aging Network facilitate / re-evaluate present service delivery systems and their adequacy to meet growing needs with less Federal and State funding.

The rise in the numbers of Aging citizens in South Carolina will impact the social, physical, and fiscal fabric of all of our cities and counties, directly and dramatically affecting local Aging, health, human services, land use, housing, transportation, public safety, workforce development, economic development, recreation, education / lifelong learning, volunteerism, and civic engagement policies and programs.

While the SC4A strongly encourages all policy makers and key informants to advocate for raises in the authorized Older Americans Act funding levels and maximum service flexibility, State and local governments will need to look at their financial capacity, as well, to ensure the Aging Network has the necessary resources to adequately serve the projected growth in the numbers of older adults, particularly the growing ranks of the 85+ population who are the most frail, vulnerable, and in the greatest need for Aging supportive services.

Our neighboring state of Georgia took a large step this year by adding \$3.5 Million dollars for various Aging services and \$1.2 Million for the Area Agencies on Aging to provide lifelong planning. Their new Kinship Care Program will enhance the Family Caregiver Support Program by extending services to grandparents under the age of 60 and adult caregivers of functionally-impaired adults over the age of 18. Caregivers of all ages, as well as individuals with disabilities, whether age-onset or lifelong, need information on and access to basic supportive services.

In order to structure a system that reaches the full long term care population, the Aging Network needs to have in place regional Aging Information Centers, State-wide, that provide the infrastructure for a host of programs, information on, access to, and choices for individuals who seek such services.

People's needs over time have not changed, but the numbers of people for whom needs must be met is changing rapidly, and service delivery systems will need to change as well. The Aging Network in South Carolina has taken major steps in preparation to address the aging of its population, but it is only the beginning. Over the next ten to fifteen years the Aging Network in South Carolina will need to have in place a non-fragmented long term continuum of care system that provides options for consumer directed care; livable communities for all ages; a comprehensive health care system that addresses the insured, the under-insured, and the un-insured; affordable and accessible transportation; and one-stop centers of information and assistance, as well as single points of entry into Aging service systems.

We have our work cut out for us! It is crucial that a pool of highly trained, effective leaders remain available to continue the critical work of the State Unit on Aging, Area Agencies on Aging, and the local Aging Network.

SC4A therefore advocates for and encourages the inclusion of an education and training certification program for AAA Directors, educational training in gerontology and geriatrics in the health and social service professions targeted to ensuring that an adequate force of skilled service providers are available to provide Aging Network services.

Thank-you for this opportunity to address the Commission this afternoon.

Testimony to the Joint Legislative Committee on Aging

May 24, 2005

**Presented by: Maria Patton, Secretary
Alzheimer's Resource Coordination Center Advisory Council**

As the Secretary for the Advisory Council to the Alzheimer's Resource Coordination Center, I want to thank you for your attention to the needs of families in South Carolina who are coping with the challenges of Alzheimer's disease and related disorders.

In 1994, the state legislature created the Alzheimer's Resource Coordination Center (ARCC) in response to the recommendations of the Blue Ribbon Task Force on Alzheimer's Disease in South Carolina. The mission of the ARCC is to improve the quality of life for persons with Alzheimer's disease or related disorders, their families and caregivers through planning, education, coordination, advocacy, service system development and communication. It is guided by a twenty-three member Advisory Council appointed by the Governor. The Advisory Council includes representatives from state agencies, professional organizations, universities, and caregivers with an interest in providing and improving care and services for the population.

In 2004, the SC Alzheimer's Disease Registry identified 42,758 persons in South Carolina with dementia. Approximately 250,000 persons care for these individuals. The Registry predicts that the number of persons affected by Alzheimer's disease and other related disorders will double in the next 15 years, and nearly triple in 25 years. A recent study by the National Institute on Aging suggests that those numbers may be higher since the declining death rate after age 65 may mean that more people will survive to the oldest ages (after 85) where the risk for Alzheimer's disease and other disorders are the greatest.

Eighty percent of care for persons with Alzheimer's disease or related disorders is given in the home by family or friends. The physical, emotional, and financial demands on unpaid caregivers are huge, especially for those caring for a person with dementia. Families want to keep their loved one at home. However, the absence of supportive services which enable families to care for the loved one at home may lead to premature placement in an institutional setting, increasing the economic cost to the state and the psychological cost to the family caregiver.

Using Medicaid statistics, care at home for an individual with Alzheimer's disease costs approximately \$13,500. Care in a nursing facility with Medicaid reimbursement costs approximately \$35,000. The average cost throughout the disease process for a person with Alzheimer's disease or a related disorder is \$174,000. Many persons do not qualify for Medicaid and must bear the cost themselves, thereby putting a tremendous financial strain on the family.

Part of the mission of the Alzheimer's Resource Coordination Center is to foster the development of a system of care that will provide families throughout the state with access to appropriate services. Whether those services are delivered in the home, the community or a residential setting, they should be responsive to the needs of the person with dementia and the primary caregiver.

Caregivers of persons with Alzheimer's disease in South Carolina have identified their top three needs:

1. Caregiver support, in the form of emotional support, family support and support groups.
2. Information and resources on the disease
3. Respite (respite services provide a break of a few hours for the caregiver from their 24 hour a day, 7 days a week job of caregiving.)

A major barrier to proper care and services for individuals in South Carolina has been the lack of resources to fund the continuum of services needed by families through the course of the progressive disease.

The \$150,000 in state funds allocated by the Legislature for the ARCC each year are used to develop community based respite programs, caregiver education and training, and other supportive services to caregivers of persons with Alzheimer's disease and related disorders. Over one hundred small seed grants to communities have been awarded since 1995. These programs include group respite, in-home respite, and a voucher based respite program in which consumers can choose the type of respite that best meets their needs. Educational programs target persons with Alzheimer's disease and their caregivers, the medical community, colleges and universities, first responders, such as police, fire and emergency medical personnel, and the general public. Recipients of the grants are required to equally match state grant funds through other resources. Of the one hundred grants awarded in the last ten years, sixty-seven programs are still being implemented throughout South Carolina.

As of December 2004, forty-five (45) respite programs have been started in twenty-eight of South Carolina's forty-six (46) counties. Educational initiatives have been funded in twenty-two counties (22). However, over 25% of South Carolina counties have no funded educational or respite programs at all. And many of the programs need supplemental on-going support to provide services to low-income families.

The ARCC is the only entity in South Carolina that awards grants to start respite and education programs in communities. It monitors and provides technical assistance to grantees to ensure that the standards remain at the highest level. It offers information and resources to the grantees as well as the general public. The ARCC continues to encourage and support grantees after their grant award has ended, offering technical assistance to encourage the sustainability of their programs.

Alzheimer's disease is one of the costliest and most uninsured health risks South Carolina families are likely to face. With the Baby Boomers aging and with in-migration, South Carolina's senior population is going to drastically increase. With the increase in the numbers of seniors and the increase in life expectancy, the impact of Alzheimer's disease on families, government and businesses may reach epidemic proportions. By preparing for the future now and providing the much-needed supportive services for families caring for loved ones at home, South Carolina will be ready to meet the challenges of Alzheimer's disease and related disorders with programs and services in place rather than trying to handle the epidemic after it has started.

We thank the Joint Legislative Committee on Aging and the South Carolina Legislature for its support of the Alzheimer's Resource Coordination Center in fulfilling its mission of improving the lives of South Carolinians with Alzheimer's disease and related disorders and their caregivers.



To: The Honorable Denny Nielson, The Honorable Walt McCloud, The Honorable Thomas Rhode, The Honorable Ronnie Cromer, The Honorable Yancy McGill, The Honorable Glenn Reese, The Honorable Linda Johnson, The Honorable Ollie Johnston, and The Honorable Bill Riser

Date: May 24, 2005

Thank you for the opportunity to testify before the Joint Legislative Committee on Aging. My topic is managing work and family caregiving responsibilities. Managing the care of aging parents is rapidly becoming the forefront of family issues today.

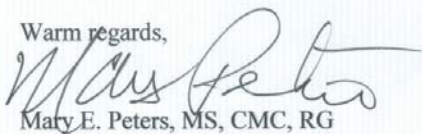
Working caregivers are trying hard to balance work and family demands, and the challenges are ever growing. **Two-thirds of working caregivers report conflict between work and family. Sixty-four percent of caregivers of the elderly are employed and caregiver stress accounts for a twenty-seven percent increase in use of company health insurance benefits. The Baby Boom Generation will spend up to eighteen years caring for an elderly parent.** There are many issues to address regarding work and family conflict, but I will discuss the issues that are having the most impact nationally, and in South Carolina.

- **Barriers:** There is a change in population demographics, with those 80 years old or older more likely to be dependent or disabled. Women are more likely to be the caregivers who balance work and family responsibilities, and this is only increasing. Employees are not feeling the support from their workplace.
- **Employer Costs:** Caregivers take more sick leave and vacation time off from the job to care for elderly loved ones. Work productivity is minimal, as employees are mentally distracted by phone calls or worry about their loved one. The possibility of workplace accidents becomes more frequent.
- **Employee Costs:** Within the next 5 years, 37% of employees will be more concerned about elder care than the care of a child. The emotional costs of caring for a loved one is great. There are lost wages and out of pocket costs that are incurred during caregiving. Most employee benefit programs do not meet all of the needs of the working caregiver.

There is a great need to provide a broad range of eldercare services to working family caregivers. Coordinating health care and community resources to reduce work and

family conflict should be a main priority for future national and state planning. Thank you for your time and attention.

Warm regards,

A handwritten signature in cursive script, appearing to read 'Mary E. Peters', written in black ink.

Mary E. Peters, MS, CMC, RG



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Testimony at Public Forum – Legislative Study Committee on Aging - 5/24/05
Susan Carlton, Executive Director

On behalf of caregiving families of all ages across the state, I raise the need for respite for anyone who is caring for someone 24 hours a day. It is the top need identified by family caregivers of children and adults alike(1). Respite is regular, intermittent breaks from round the clock caregiving.

Weekly I hear from families doing extraordinary things to keep their mothers, fathers, husbands, wives, siblings, and children at home. There are some who make sacrifices to care for friends. They give up jobs, go without medical insurance, pay hundreds of their own dollars to supplement the social security and disability payments of their loved ones, some move several states over, bridging responsibilities between two homes and families. It is a medical and mental health necessity to have a break when giving this kind of care, no matter how devoted a person is to their loved one!

An estimated one fourth of American families are involved in some form of care giving. Not all of them need respite, but our best "guesstimate" is that at least 37,000 South Carolina families do. We ALL have a responsibility to help them - private and public organizations, faith communities, and legislators. This is not "them;" it is US! If not now, someday.

We expect families to carry on without a break and they expect it of themselves. This can lead to depression, isolation, stress, and burnout. And it can lead to neglect or abuse of the care receiver. (2) A society serious about family values can not ignore that! We know that as little as 4 hours a week of respite can make a huge difference for most family caregivers. (3) Calculated at \$10.00/hr., respite is about \$2,000 a year compared to \$35-40,000 for nursing home care.

- The first need is for respite to be easily found. We need a central point of contact, so that families have to make only one or two phone calls for sitters, referrals, and financial help.
- Families want respite to be offered in group settings and in the home.
- It should be available for short periods such as overnight, a long weekend, or a full week
- Crisis respite should be available.

- Families should be able to select their respite care providers, with the option of completing waivers for family members who already know the loved one. Wouldn't you want to know and trust the person with whom you leave your loved one?

As the attached chart shows, the largest amount of publicly funded respite is found in S.C. Department of Disabilities and Special Needs and in the Community Long term care program. A secure state match for Medicaid is essential to maintain and expand these programs. Cuts in Human service budgets are hurting families and respite is one of the first services to go. This committee could exert its influence in calling for a Summit on Respite and Family Caregiving, to convene leaders and people of influence to address workforce issues, opportunities to mobilize volunteers, students, and their parents with educational vouchers, and the issues of choice for families.

Policy considerations must also include those caring for someone with mental health issues. These families have little respite and have to be in crisis before the state intervenes. Then their loved one is removed for treatment outside of the home, disrupting life for everyone and costing far more than if we'd given a little respite in the first place. We spend approximately \$40 million each year to remove South Carolina children with serious emotional disorders from their homes.

Hundreds of family caregivers (usually mothers and grandmothers) care for adult family members with mental illness whom they fear to leave alone at home for long. Like families whose loved ones have a midlife degenerative disorder, their need is often for weekend and short-term overnight respite rather than a regular break every single week. The loved ones can be left alone for a few hours, but not overnight without care, medication management, and supervision.

OASIS may one day provide respite to parents whose children have serious mental health disorders through the S.C. Department of Mental Health, but only if, after the 5 year federal grant ends, South Carolina commits to sustaining it. We can't do that with a decimated Department of Mental Health and no Medicaid Waiver for this population. And, finally, if federal allocations to the Family Caregiver Support Program are increased, South Carolina must be ready to provide the state match for the Lt. Governor's office to be able to draw down the maximum amount possible.

Families want to care for their loved ones at home, but care giving lasts longer in all populations in this decade than it has ever lasted before. Caring for the family caregivers providing care is crucial. Respite is not a luxury. It is a medical and mental health necessity!

- 1) Continuum of Care 1999, 2000, 2001; Family Connection of S.C., 1997; Family Caregiver Support Program, 2001.
- 2) a) Without respite there is greater likelihood of abuse. In a 2001 study conducted in 17 U.S. areas: 11% of caregivers stated they might have abused their child had they not received respite services. Ninety-one percent report experiencing less stress now they have respite services (9/2001, ARCH Network news.)

b) Parent-reported mental health treatment for stress is 2 to 3 times higher for parents of children with special health care needs versus that reported by parents of well children (The Ontario Child Health Study. Cadman, Rosenbaum, Boyle & Offord, 1991).
- 3) a) One 1974 study of hospitalizations of older caregivers cites 69% fewer hospitalizations of both caregiver and loved ones. In another study 64% of caregivers of the elderly receiving 4 hours of respite per week after one year reported improved physical health, 78% improved their emotional health, and 50% cited improvement in the care recipient as well. Forty percent said they were less likely to institutionalize the care recipient because of their respite. (Theis, s.L., et al. 1994.)

b) In one of the few controlled studies of the effectiveness of respite care for families with children with emotional and behavioral disorders, families who received an average of twenty-three hours per month of preplanned respite care reported fewer out-of-home placements, greater optimism about caring for their child at home, and reduced caregiving stress compared with similar families who were on a waiting list (Bruns & Burchard, 2000). In addition, the families reported that their children displayed fewer negative behaviors in the community. Greater use of respite services was associated with more positive outcomes, pointing to the need to increase the intensity of respite services to impact some outcomes.

STATE SYSTEM

WHERE FAMILIES FIND RESPITE IN S.C. (3/05)

Respite = short term, temporary relief from 24-hour care giving.**

OTHER

S.C. Dept. Disabilities & Special Needs Medicaid Waiver funds (1) State funds (2)

Community Long Term Care (CLTC-part of SCDDHS) Medicaid waivers: HIV/AIDS (3) Ventilator dependent (4) Elderly/disabled (5)

Continuum of Care (6)

DSS Foster Care (7)

Dept Mental health (8)

Alzheimer's Resource Coord. Center (9)

Gov. Developmental Disabilities Council (10)

Family Caregiver Support Program (11)

** Distinguished from full time child or adult care that enables families to be employed. Can be in-home or out of home, for crisis or extended breaks. Top preference is for respite provided in home by non-custodial family members or friends. It is cost effective: at \$10 an hour x 4 hours a week, respite can be provided for \$2,080 a year. One difficulty in quantifying respite is that personal care, homemaker & recreation serves as a form of respite, though not classified as such. There is very little overnight care available, highly needed by caregivers whose sleep is often interrupted.

Alzheimer's Assoc. (12)

Assisted Living facilities (13)

Multiple Sclerosis Soc. (14)

Family Connection-SC (15)

Adult Day Care Centers/Programs (16)

Hospice (17)

In-home care providers (18)

ARC (19)

Skilled nursing facilities (20)

SC Respite Coalition (21)

Faith communities (22)

Private M.H. Providers (23)

Children Unlimited (24)

Sr. Companion Program (25)

Palmetto Health Alliance (26)

Recreation Commissions, sports leagues/riding (27)

Note: though there appear to be many sources, there is actually very little respite in S.C. compared to the families that need it. These services are not, for the most part, coordinated.

- 1) Largest source of public respite funding for Devel. disabilities, head & spinal cord injury, and autism. Federal funds matched by state funds within DDSN. Some people on autism spectrum ineligible. 6,000 on waiting list for housing. 3,400 family caregivers 55+ caring for adults with disabilities.
- 2) Small amount of state funded respite, more flexible for families & located in DDSN/Family Support Line item. Has been impacted by budget cuts, spread over growing # families. Families experience cut backs by some boards as early as October of each fiscal year.
- 3) 4) & 5) (CLTC) Provided for Medicaid waiver eligible individuals close to institutionalization. Overnight respite provided in Comm. Residential Care or skilled care facilities, but hard to secure due to lack of empty Medicaid beds. Waiting list for # 5) is 3-6 months, a delay that causes some families to institutionalize before they can enter the program. No waiting lists for 3)&4). Personal Care Aides relieve families, but only there for short periods a few times weekly. In-home respite offered only for patients on ventilators but, due to nursing shortage, can hardly provide. Case

- management feature is important. No equivalent for anyone not eligible for Medicaid. Mid-income families on their own to find services & pay.
- 6) Gov. Office Program provides respite for small number of parents whose adolescents have serious emotional disorders (SEDs)
 - 7) Foster Families provide respite for each other, so children switch homes to give foster parents a break. DSS also operates Managed Treatment Program for children with SEDs who "de-escalate" & are removed from their homes. DSS protective services workers alarmed by lack of crisis care.
 - 8) Little of preventive nature. Teens or adults must "de-escalate" into crisis for family before we remove from home. New OASIS grant will develop sustainable respite model for teens with SEDs. Wrap around services pilot programs now provide small amount of respite for a few parents.
 - 9) Lt. Governor's Office on Aging - State funds provide small grants to start respite programs or offer vouchers to families. (In 2004, 286 caregivers received an average of 61 hours of respite for an average of \$330 each, from one of 10 ARCC funded respite sites.) Total for Alzheimer's education and respite grants \$150,000 annually.
 - 10) Governor's office division uses federal funds to give one or two grants of \$25-30,000 each year to fund innovative respite programs for parents.
 - 11) Lt. Gov.'s. Office on Aging - Federally funded & matched with state dollars - provides small grants to qualifying family caregivers of people 60+ & grandparents 60+ raising grandchildren under 18. (In 2004, 1416 caregivers received an average respite grant of \$490 that allowed them to purchase an average of 96 hours of respite each.) Very flexible program & differs slightly in all 10 regions. Funding does not meet requests for services.
 - 12) The two Alzheimer's chapters provide vouchers of up to \$500/year. Their fund (some from drug co. settlement) will be diminished after 12/05. Also has lists of providers. Palmetto Chapter (28 counties) gave \$341,890 to 718 individuals in 2004. This is an average of \$476 = 77 hrs @ \$13/hr, 10 days in an adult day care center or 4.5 days/night in assisted living @ \$110/day. Upstate Chapter (18 cos) gave \$335,000 to 575 indiv. @ avg \$523.
 - 13) Privately funded institutional non-skilled care, starting @ appx. \$110/day w/ added charges. Covered by some long term care insurance. 494 Comm. Residential Care Facilities, but not usually available for respite as licensed for lower level of care.
 - 14) \$5,000 available per year for family respite. Last year provided \$1,500 to 3 families. Once served by DDSN, this population is no longer eligible.
 - 15) Fam. Connection of SC, Inc. has 13 Respite Cooperatives run by parents of children with disabilities and volunteers. Most meet once/month & are in faith communities. Use volunteers from congregation & community. 194 families served monthly.
 - 16) Most for elders but a few for young/middle adults; a few for MH. 97 DHEC licensed. Medical model often covered by Medicaid; never Medicare. Appx. \$50/day, Medicaid rate \$39. Fewer social model centers as entirely privately funded, but 1-2 in state all volunteer. Low cost Brookdale model, 1/2 day programs operate 1-4 days/week, use volunteers (see 22). Day programs, sheltered workshops in most counties subcontracted from DDSN.
 - 17) For terminally ill patients within 6 months of death. 58 DHEC licensed programs. Volunteers provide respite or it is paid for by donations unless patient enters hospital under their insurance or Medicare/Medicaid. Is the only formal option for families of loved ones with ALS; 0 until pt. dying.
 - 18) Privately funded, except by long term care insurance unless client in CLTC. Providers are chosen & rates set by families \$13/hr for non-med. care provided by agencies. Home health (a medical service) covered by Medicaid/Medicare trains family members in care, but no respite.
 - 19) Serves 20 clients with disabilities with adult socialization program - Midlands region only.
 - 20) 191 DHEC licensed facilities. Available more readily for private pay patients; few Medicaid beds available for respite or CLTC patients.
 - 21) Advocacy for respite, referral to respite resources & education about lifespan respite & how to make use of it. Education for Faith Communities.
 - 22) Many families whose loved ones have disabilities can not find a church home, but there are some programs. Care Team ministries; special worship services; adult care centers include mothers' mornings out. 15 Brookdale model - social part time Alzheimer's day care programs; SC Christian Action Council AIDS Care Teams. Some faith communities may also provide occasional funding for respite.
 - 23) Private residential MH providers for adolescents with SEDs removed from home, paid by Medicaid, insurance, or privately. 3 mos - 1 year stay.
 - 24) Small voucher fund for adoptive parents of children w/ spec. needs.
 - 25) Volunteers matched to fellow seniors, funded through Corp. on National & Community Service. 4 programs in SC. serve 30-40 families/year.
 - 26) Palmetto SC Care & Medically fragile children's program give some respite to small families in Col. Eastley and soon Charleston (w/ MUSC).
 - 27) There are a few inclusive programs for children & summer camps. Also non-profit & church camps, riding programs, sports leagues for kids w/ special needs that relieve parents for short periods. There are not many overnight opportunities.



Implementing Senior Service Best Practices

SAGE Institute
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**Joint Legislative
Committee on
Aging**
May 24, 2005



SAGE Institute

*Improving the life of South Carolina
seniors by...*

**Supporting the Advancement
of Geriatric Excellence**

Focus:

- ◆ **Advancing Services for Seniors at ALL ECONOMIC LEVELS**
- ◆ **Collaborations across For-Profit, Non-Profit, Healthcare and Non-Healthcare Senior Service Providers**
- ◆ **Non-government funding solutions**

Current Business since June 2002...

- ◆ **Housed at Spartanburg Regional Healthcare System**
- ◆ **Managed by SCHA**
- ◆ **Paid through grant funds and in-kind support**

***SC Senior Service Provider
Focus Groups 2004***

3 Top SC Service Weaknesses

- ◆ **Transportation**
- ◆ **Mental Health**
- ◆ **Middle Economic Level
Services**

CHALLENGE ONE..

"We need to focus on replicating senior service best practices NOT dependent on government funding".

**...The SAGE Institute is accomplishing this through 10
Geriatric Network Teams
across SC**

34 Best Practice Replications in Progress across SC

Replications in progress:

Examples...

**Transportation (8 committees), Community
Case Management (5 committees), Middle
Economic Crisis Management (2 committees),
Mental Health Services (3 committees),
Home Support Services (4 committees),
Provider Education (3 committees),**

....etc.

CHALLENGE TWO..

"We need to develop a committee to present to the SC Legislature important issues from across senior services."

...The SAGE Institute can do this...450 senior service providers across the state participating in *Geriatric Network Teams*.

Why?

- ◆ **Individual senior service sectors present only their issues...LTC, Hospitals, Government, etc.**
- ◆ **A Senior Service Committee will address service issues from ACROSS service sectors**
- ◆ **A Senior Service Committee will better be able to focus on the seniors as customers...crossing all economic levels and all care needs**

Support the
SAGE Institute



The SAGE Institute
Geriatric Best Practices Initiative

*Improving the life of South Carolina
seniors by...*

**Supporting the Advancement
of Geriatric Excellence**

**Visit our website for
4,000 SC senior
services & contacts...
www.bestgeriatrics.com**

My name is Lynn Stockman, Executive Director of Newberry County Council on Aging. I am representing the South Carolina Association of Council on Aging Directors. This organization serves as an advocate for Council on Aging and the clients they serve.

The Councils on Aging have made tremendous strides in serving the elderly of this state and are the guiding force in providing a better quality of life for older people of South Carolina. They provide services such as home delivered meals, group dining or senior centers, transportation, homecare, adult day care, disease prevention and health promotions.

These local service providers have low indirect costs and the ability to leverage local and private funds to increase service dollars and ultimately expand services. They have years of experience in direct service delivery and are truly known as the Senior Focal Point in the community.

The senior population is the fastest growing population in our state with those individuals over 85 being the fastest with a growth of 63.5%. It must be pointed out that this group is also the most vulnerable and the most isolated.

Service dollars are scarce and emphasis must be at all times be targeted to maximize service dollars at the local level.

A good example of maximizing dollars at the local level is the Senior Center Permanent Improvement funds. In 1991, the South Carolina Legislature established Senior Center Permanent Improvement Program and appropriated monies from State Bingo tax to construct new senior centers and to renovate or improve already existing monies.

It is vital that these funds be continued to build and or renovate already existing centers that offer a wide range of services to seniors such as group dining and adult day care centers.

It is imperative that Councils on Aging continue to receive funding to maintain programs for our older generation through which they can remain independent and retain their dignity.

JOINT LEGISLATIVE COMMITTEE ON AGING
PUBLIC HEARING

May 24, 2005

Sue L. Scally, Ph.D.

Thank you for this opportunity to speak to you today about an issue that is of great importance to older adults and their families. The issue that I would like to address asks this fundamental question: “If you need assistance in caring for yourself, how would you like to receive that assistance?” Put that way, it becomes a very personal question for each of us, both for ourselves and for those that we care about.

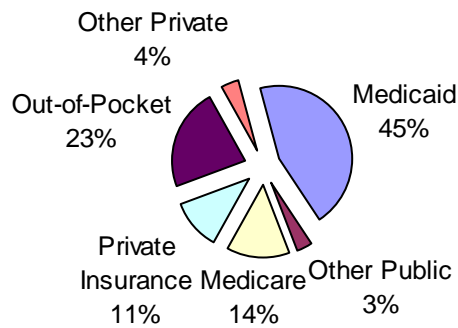
Many older adults and other persons with disabilities require assistance with activities of daily living and/or chronic health needs. Such assistance makes it possible for them to maintain some independence and live in their communities. The type and degree of assistance required varies widely. It may include assistance with personal care (e.g., bathing, feeding, dressing), assistance with meal preparation and other household chores, help with mobility and finances, medical supplies, equipment, medication, or skilled nursing care.

Issues related to long term care are increasing in importance with the growth of the senior population. The 2004 AARP report, *Across the States: Profiles of Long-Term Care*, reports that 22.2% of South Carolina’s 65 and over population has self-care or mobility limitations. The rapid growth in the 85+ population raises serious issues regarding the availability of long term care and how it is provided in the state.

Consumer research in South Carolina, as in many other states, indicates that consumers wish to have more choice in how they receive services. However, the current system has significant barriers to consumers getting long term care services that are consistent with their values of: 1) receiving services at home and in the community, rather than in institutional settings; and 2) having control over how services are provided and who provides them.

Why is this so? The system that currently provides long term care is shaped by two powerful forces:

1) How care is financed – Most long term care expenses are not paid directly by the consumer, but are paid on behalf of the consumer by third parties such as government programs or insurance companies. Public funding pays for approximately 62% of long term care with the remainder covered by out-of-pocket expenditures, private insurance or other sources. Medicare pays only about 14% of the costs of long term care while Medicaid pays 45%, making it the largest payer of long term care. Thus, to a large extent, the long term care that people receive is often dictated by the requirements and conditions of the Medicaid Program. The chart below shows the sources of funding for long term care.



Source: Kassner, Enic. *Medicaid and Long-Term Services and Supports for Older People*. AARP. 2004

2) Who provides the care – Payers control who may be reimbursed for providing long term care services. Despite the fact that approximately 80% of all long term care is provided informally by families and friends, they typically are not eligible for reimbursement through public funding sources such as Medicaid and Medicare. Based on a traditional “medical model” of long term care, most payers have concentrated their resources on care provided by institutions and by professionals licensed by the state. So while consumers prefer care provided in their home and support services provided by family, friends, or other persons of their choosing, care must often be provided in “facilities” and even home care must be provided by licensed or certified professionals. These professionals influence or control the type, amount, location, and provider of services received.

South Carolina FY 2003 Medicaid expenditures for long term care for the elderly reflects that over 80% of expenditures went to provide institutional care.

SERVICE	PERSONS SERVED	FY 2003 EXPENDITURES	% OF LTC EXPENDITURES
Nursing Home Services	17,264	\$418,568,552	83%
Home/Community Based Waiver - Elderly/Disabled	13,589	\$73,834,320	15%
Home Health	7,765	\$12,191,153	2%
TOTAL	38,618	\$504,594,025	100%

Source: Burwell, Brian; Sredi, Kate; and Eiken, Steve. *Medicaid Long Term Care Expenditures – FY 2003*. Medstat. May 25, 2004. and SC DHHS Annual Report on Home and Community-Based Services Waiver (CMS 372 Report).

Note: Persons served are based on 11,522 Medicaid permit days for nursing homes; 11,000 approved slots for the waiver, and a limit of 75 visits per year per home health recipient.

To promote a system that provides for consumer choice and direction within the public sector, having the money “follow the person” is an approach advocated by the federal Centers for Medicare and Medicaid Services. States can

allocate funding to support persons in need of long term care services, without narrow restrictions on the type, timing, location, and provider of services. Working within a limited budget based on the level of their disability, consumers (and families or other representatives if necessary) make the decisions about the kinds of services that will work most effectively for them, and the location, timing, and provider of those services. As consumers make changes in those decisions over time, the money budgeted for the person would follow them to the new services or providers.

South Carolina already has a Medicaid *Independence Plus* waiver under the President's New Freedom Initiative. Through this initiative, persons in the Medicaid Elderly/Disabled Waiver are offered the option of self-direction, with the assistance of a care advisor and a financial management service. It has been piloted in two regions of the state and is now ready to begin the process of being implemented statewide. Additionally, South Carolina's Family Caregiver Support Program operated statewide through the Lt. Governor's Office on Aging provides increased opportunities for caregivers to make care decisions.

Consumers who pay for their own long term care have the full array of choices about their care available to them (assuming services are available through the market place and at an affordable price). Therefore, decreasing dependence upon public financing is another way to promote individual control and choice.

Recommendations

- ✓ Expand the concept of consumer choice to all public funding for long term care services. As part of this expansion, the state should no longer earmark long term care funds for certain services or providers, instead allowing those funds to "follow the person" to the service and provider of their choice. This would allow individuals and families to make decisions about their greatest needs and how they can be most efficiently and effectively met. This approach also recognizes the fluidity of needs of older adults and develops a payment structure that facilitates smooth transitions between service systems.
- ✓ Recognize that informal care is the backbone of the long term care system and must be supported by public policy. Support informal caregivers by providing a broader array of supports from which they can choose and by providing financial assistance to informal caregivers for providing care.
- ✓ Support federal legislation that will permit South Carolina and other states to implement a program that improves access to affordable private long term care insurance. Known as the Long-Term Care Partnership Program, the program permits consumers who exhaust benefits under their private long term care insurance to become eligible for services funded by Medicaid without having to meet the usual financial eligibility requirements. This enables consumers to avoid a spend-down of assets. The program is a win-win in that it saves the government money at the same time that it provides an incentive for consumers to purchase long term care insurance.

Thank you again for this opportunity to speak to you on an issue that makes such a huge difference in the quality of life we can hope to experience in our older years.

Tom Sweeney

I'm a humble volunteer serving on a committee who reports to Nela and Bruce. I represent private industry - the insurance industry. And a lot of the issues that are being talked about here are going to require years of education. Our business of education; we don't sell, we help people choose. I cannot speak for the industry; I can speak for our office. We would welcome you to request us to help you in the education process. Many of the things that go on can be handled through private responsibility for financial planning. So, we welcome your request to help us to help you to get the word out to people that they need to plan as they get older. And we think that planning starts in college so we welcome you to ask us to help. I'll be working through Nela's committee to provide any assistance that I can but we welcome your request for somebody to help out.

Helen Dills Pittman

My name is Helen Dills Pittman and I am just a simple tax payer, a mother of an 8 year old child, the wife of a 77 year old husband and the daughter of a mother who died 3 weeks ago in a nursing home. This committee and the Legislature has done great things in aging over the last few years. I would like to congratulate you for those things beginning with

A few years back you allowed dental hygienists to start coming in to nursing homes. For years we have known that if you can't eat your food, you can't be healthy but we never allowed for those dental services before. I'd like to say that that has been wholeheartedly embraced by the nursing home industry but it has not because there has not been enough publicity nor incentive of that issue to get those hygienists in there. I'd like for you to also in your research to look at a dental program that is going on in North Carolina nursing homes where they actually take full dental care to nursing home patients. It only makes sense. If you can't eat, you can't be healthy. It's one area that we say that we're going to provide a healthy meal but unfortunately if you can't eat it, it doesn't do any good for it to be sitting there in front of you.

Also, in nursing homes our vulnerable individuals depend on our ombudsmen to come in and protect their rights. You must understand how our ombudsmen programs works in this state. In most areas, it is operated under a Council of Government (COG). The COG Director hires and fires those ombudsmen; not the bureau of aging – they may provide the education but that's it. I know this because I was trained as an ombudsman. If you are under the direction of someone who can hire and fire you do your evaluations, many times you are left in a situation of this is a political organization, don't make waves. If someone has not been killed, maimed, it's ok. You're certainly not going to go in at 3:00 am on the last shift to see what's going on. For several years we have talked about doing a volunteer ombudsman program. This could make the greatest difference in the world to these vulnerable individuals. Please, please go forward with the work that has already been done in this volunteer ombudsman program.

Next I would like to thank you so very much for (several years back) removing the special sales tax exemption so that meals that were being delivered in this state could be better at a level playing field. 7% sales tax does make a difference and it has made a difference in the improvement of the quality of food that our seniors now get.

I'd like to also thank you for working toward and going forward with the Lt. Governor and the Bureau on Aging in providing RFP's this year for services. But, when you talk about services you only talked about services that were provided at the Council on Aging level. When you look at services that were provided for the aging population of this state, you must also look at the AAA. They provide information & referral, family caregivers, I-CARE counseling, ombudsman services, Title V senior services, Medicare referral and are most often housed in the Council on Government (COG). What is the mission of the COG, the training of the COG, to assist the AAA's in doing this? Is there a mission statement to truly improve the quality or quantity of life for our citizens? Or does their mission statements read much more about simple economics, highways, planning, zoning concrete. They don't read a whole lot about help and heart. Sometimes if you want the programs to go in the right direction, you've got to make sure that the mission, the drive, the accuracy is there. In this state, we have several different housings of our AAA's. Some of them are done on an independent basis. Most of them are in our COG's.

I would like for you to look at one other possibility and that would be housing the AAA at the Clemson Extension Services. If you think about this for a moment, it will become clear to you that information & referral – the extension agents have years of providing information & referrals to all families. When you're dealing with insurance companies, you're dealing with very low income and trying to get all your bills paid, you need budgeting help. Clemson does that. Only a couple of years ago, we had a program in this state called Be Smart. It won a national award. It was for seniors and it was handled out of the Central Council of Government here in Columbia. But they partnered with Clemson Extension because Clemson understands

grass work network. They understand working with families; they understand education; they have the background and training to do that. Who else is better qualified to talk to our seniors about nutrition, about daily activities of life, about gardening, about simple things like “find it-file it”. It’s a simple tool that they have used for years that has helped seniors.

End of Tape